

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/10/2010
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ELIZABETHTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1641 HIGHWAY 19E ELIZABETHTON, TN 37643		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000			
F 157 SS=D	<p>During the annual recertification survey and complaint survey #25042, #25321, #25506, #26310, #26320, #26936 and #27021 conducted on November 8, 2010, at Life Care Center of Elizabethton, no deficiencies were cited in relation to the complaints under 42 CFR PART 482.13, Requirements for Long Term Care.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update</p>	F 157	<p>F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) SS=D</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 3 was immediately re-weighed and the physician notified and family of the weight gain on 11/10/10.</p> <p>Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken? All residents have a potential to be affected. All residents that have re- weight + or - 5 will have MD notification within 24 hours.</p> <p>What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur? Re-education was done with all restorative CNA's, by ED 11/12/2010-12/01/2010, to notify the hall nurse of any re-weight + or - 5 pounds. The Dietary Manager, and DON were re-educated by the ED on the need to Notify MD and family the next day of weight being obtained. The Education was started on Nov. 24th 2010 - 12/05/2010 by the DON and Unit Managers to all nursing staff and all nursing shifts.</p>	12/10/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interviews, it was determined the facility failed to ensure staff notified the attending physician of significant weight gain for one resident (#3) of 28 residents reviewed.</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on January 15, 2010, with diagnoses including Congestive Heart Failure, Chronic Kidney Disease, Dementia with Behavioral Disturbance, and Depressive Disturbance.</p> <p>Medical record review of the resident's Weight Change Alert Report dated November 4, 2010, revealed the following weights: October 5, 2010, 164.20 pounds; November 1, 2010, 199.20 pounds. Continued review of the report revealed a 35 pound weight gain from October 5, 2010, to November 1, 2010.</p> <p>Medical record review of the resident's record revealed no evidence the physician had been notified of the resident's 35 pound weight gain.</p> <p>Observation of the resident on November 8, 2010, at 1:15 p.m., in the resident's room, revealed the resident sitting in a wheel chair, alert, responsive and without respiratory distress.</p> <p>Interview with the Certified Dietary Manager and Minimum Data Set Coordinator (MDS</p>	F 157	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur? What quality assurance program will be put into place?</p> <p>All weights of + or - 5 pounds will be monitored weekly by the Ed or Designee to ensure the MD and family have been notified. The results of the Audits will be taken to the monthly PI committee meeting by the ED/Designee. Beginning with the next PI meeting set for December 7th, 2010.</p>		

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F 157	Continued From page 2 Coordinator) #2, in the Medical Records Office on November 8, 2010, at 4:00 p.m., confirmed the physician had not been notified of the resident's weight gain. Continued interview with the Director of Nursing (DON) in the DON's Office on November 8, 2010, at 4:10 p.m., confirmed the facility failed to notify the physician of the resident's 35 pound weight gain.	F 157			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	F 278 483.20(g) -(I) Assessment Accuracy/ F 278 483.20(g) -(I) Assessment Accuracy/ Coordination / certified. SS=D What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #13's MDS coding was changed to reflect weight gain on 11/10/10 by MDS coordinator. Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken? All residents have a potential to be affected.		12/10/10

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F 278	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to have an accurate Minimum Data Set (MDS) for one resident, #13, of twenty-eight residents reviewed. The findings included: Resident #13 was readmitted to the facility on February 9, 2010, with diagnoses including: History of an Anterior Myocardial Infarction, Depression, Osteoporosis, Hypertension, Anxiety, Syncope, Bronchitis, History of Closed Head Injury, and Bipolar Disorder. Medical record review of quarterly MDS dated May 10, 2010, and August 2, 2010 revealed an answer of 1(yes) in section "Weight loss", in the section that refers to "Weight Change". Continued medical record review of the Weight Chart History revealed the resident's weight on February 9, 2010 was 156 pounds, on October 5, 2010, 192 pounds, with no documentation of weight loss during this time period. Interview with MDS Coordinator #1 on November 9, 2010, at 10:45 a.m., in the MDS office, confirmed the facility failed to accurately code the MDS dated May 10, 2010, and August 2, 2010, to reflect a weight gain.	F 278	MDS Coordinators will review each others assignments weekly for accuracy of weights. Re-educate on proper coding for weight changes. Re-educate MDS Coordinators of the importance of MDS coding. Re-education to be done by RUS, completed by 12/07/2010. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur? MDS coordinators will be re-educated on proper coding of the MDS for weight changes by the RUS, completed by 12/7/2010 How the corrective action(s) will be monitored to ensure the deficient practice will not recur? What quality assurance program will be put into place. The MDS coordinators will audit each others resident weekly. 20 residents per week will be audited for accurate coding of weight change. The audits will begin on Nov. 24 th 2010 and finish on 02/24/2011. Findings of the audits will be taken to the monthly PI committee meeting by MDS Coordinator/Designee. The next PI meeting is set for Dec. 7 th		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	F 281483.20(k)(3)(i) services Provided Meet Professional Standards SS=D What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #23 's MD was notified on 11/10/10 in regards to Antibiotic not started on 10/27/10, different antibiotic started on 10/31/2010.		12/10/10

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F 281	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow Physician's Orders for one (#23) of twenty-eight residents reviewed. The findings included: Resident # 23 was admitted to the facility on August 19, 2010, with diagnoses including Dementia, Psychosis, Diabetes, Hypertension, and Heart Failure. Medical record review of a Microbiology Urine Culture Report dated October 25, 2010, revealed, "... (greater) 100,000 cfu/ml Staphylococcus Aureus (type of bacteria)...Methicillin Resistant Staphylococcus Aureus Isolated." Medical record review of a Physician's Order dated October 27, 2010, revealed, "...Doxycycline 100mg (antibiotic) po (by mouth) BID (twice a day) X (times) 7 days..." Medical record review of a Physician's Order dated October 31, 2010, revealed, "Discontinue the Doxycycline and give Bactrim DS one tab twice a day for 7 days." Medical record review of the Medication Administration Record dated October, 2010, revealed no documentation the Doxycycline was administered as ordered by the Physician. Interview with the Director of Nursing and the Regional Nurse on November 10, 2010, at 12:00 p.m., in the hall, confirmed the Doxycycline had not been given as ordered by the Physician.	F 281	Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken? All residents have a potential to be affected. RE-educate license nursing staff, RN's and LPN's on ensuring that orders are processed in a timely manner. Education will be done by the DON, or Unit Managers and will be completed by Dec 3 rd , 2010. What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur? Night shift nurses will do 24 hour chart audits to ensure orders have been processed. The Audits will begin on Nov. 24 th . How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Findings of the 24 hour chart audits will be taken to the monthly PI meeting by the DON or Designee beginning with the meeting set for Dec 7 th , 2010.		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312			

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F 312 SS=D	<p>Continued From page 5</p> <p>DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview the facility failed to provide mouth care to one (#2) of twenty-eight residents reviewed.</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on September 5, 2005, with diagnoses including Anoxia Drain Damage, Depression, Anxiety, and Convulsions.</p> <p>Medical record review of the Minimum Data Set dated July 30, 2010, revealed the resident had short and long term memory, required extensive assistance with decision making, and required totally assistance with all activities of daily living.</p> <p>Observation on November 9, 2010, at 10:40 a.m., revealed the resident sitting in a Geri-chair neatly dressed. Continued observation revealed a thick white crusted substance covering the entire surface of the lips.</p> <p>Interview with a Licensed Practical Nurse # 1 on November 9, 2010, at 10:45 a.m., in the resident's room, confirmed the facility failed to provide mouth care to the resident.</p>	F 312	<p>F312 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>SS=D</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 2's mouth care was given immediately on 11/10/10.</p> <p>Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken? All residents who are unable to carry out activities of daily living have a potential to be affected. Nursing staff and C.N.A.'S will be re-educated by the DON, or Unit Managers on ensuring that mouth care will be given daily and as needed. Education started on 11/24/2010 and will be completed by Dec 3rd.</p> <p>What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur?</p> <p>CNA's will be re-educated that the mouth care is part of AM and PM ADL care as well as whenever it needed. The re-education will be done by the DON, or Unit managers</p> <p>education started on 11/24/2010 and will be completed by Dec 3rd 2010.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur? What quality Assurance program will be put into place?</p> <p>All residents requiring mouth care will be audited daily by the hall nurse, visually and by tracking logs used by each shift to ensure mouth care is being done. The findings of the audits will be taken to the monthly PI meeting by the DON or Designee. The next meeting is set for Dec. 7th 2010.</p>	12/10/10
F 514	483.75(l)(1) RES	F 514		

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F 514 SS=D	<p>Continued From page 6</p> <p>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to ensure accurate documentation in one record (#7) of twenty-eight records reviewed.</p> <p>The findings included:</p> <p>Resident #7 was readmitted to the facility on September 6, 2010, with diagnoses including: Insulin Dependant Diabetes Mellitus, Hypertension, Congestive Heart Failure, Dementia, Pressure Ulcer and Coronary Artery Disease.</p> <p>Medical record review of Nurses Notes dated October 26, 2010, at 2:00 p.m., revealed " ...Residents BS (blood sugar) this am was 24. Resident was unresponsive & not moving. A Glucagon injection was given IM (intramuscularly) and rechecked 20 mins (minutes) later BS was</p>	F 514	<p>F 514 483.75(l)(1)Resident Records-Complete/Accurate/Accessible SS=D</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #4 's MD was notified on 11/9/10 in regards to Hypoglycemic episode and Glucagon Injections Resident received dated 10/26/2010</p> <p>Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken? All diabetic residents have a potential to be affected. Unit managers or DON will re-educate nurses on documentation of physician notification. The re-education started on 11/24/2010 and will be completed by Dec 3rd 2010.</p> <p>What measures will be put into place or systematic changes will be made to ensure that the deficient practice does not recur? Unit Managers to do daily audits of all diabetic residents to ensure the physician notification of episodes of hypo/hyper glycemia is documented by daily tracking sheet</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Findings of the daily audits will be taken to the monthly PI meeting by the DON or Designee beginning with the PI meeting set for Dec. 7th 2010.</p>	12/10/10	

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F 514	<p>Continued From page 7</p> <p>30. A second Glucagon injection was given IM and BS was rechecked 20 min later and it was 34 with resident semi conscious and partially responsive. Orange juice was given po (by mouth) over 30 minutes with BS finally rising to 79. An early breakfast tray was called for and resident fed early. 30 mins after eating residents BS was 139 and stable without problems further with BS..." Continued medical record review of the October 2010 Medication Administration Record (MAR), revealed no documentation of the Glucagon being given on October 26, 2010.</p> <p>Interview on November 8, 2010, at 3:15 p.m., in the North Wing nurses station, with LPN (Licensed Practical Nurse) #1, confirmed there was no documentation in the medical record the physician had been notified of the October 26, 2010 blood glucose results. Interview with the DON (Director of Nursing), on November 9, 2010, at 11:15 a.m., in the DON office, confirmed there was no documentation in the medical record that the physician was notified.</p> <p>Interview with the facility physician on November 9, 2010, at 3:30 p.m., in the North Wing nurses station, confirmed the physician had been present in the facility on October 26, 2010 and had been notified of the resident's low blood sugars.</p> <p>Interview with the DON on November 10, 2010, at 11:00 a.m., in the North Wing nurses station, confirmed the facility failed to document the notification of the physician and the administration of the Glucagon.</p>	F 514			